UNITED NATIONS

ST

Secretariat

ST/IC/1991/33
17 May 1991

INFORMATION CIRCULAR

To: Members of the staff at Headquarters

From: The Controller

Subject: RENEWAL OF THE HEADQUARTERS MEDICAL AND DENTAL INSURANCE PLANS AND ANNUAL ENROLMENT CAMPAIGN, 3-7 JUNE 1991*

General

1. The purpose of the present circular is to announce:

(a) The 1991 medical and dental insurance enrolment campaign;

(b) Changes in the premium rates that will come into effect on 1 July 1991;

(c) Modifications in benefits in several plans which will come into effect on 1 July 1991 (see in particular paras. 21 and 24).

Premiums, which are shared between the participants and the Organization, have had to be increased moderately in order to meet the projected costs of the plans resulting from the continuing escalation of medical costs at Headquarters. The new premium rates as well as the percentages of salary pertaining to staff members' contributions to the premiums for the various plans and categories of coverage are set out in annexes I and II to the present circular.

Annual enrolment campaign

2. All staff members holding appointments of three months or longer (or six months or longer for dental coverage) under the 100 or 200 series of the Staff

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* Personnel Manual index No. 6170.

Rules, 1/ whose duty station is New York and who are not enrolled in a Headquarters medical/dental insurance plan may enrol during this annual campaign. In addition, those currently enrolled may take the opportunity to review their coverage and change from one plan to another, or change their coverage in respect of the members of their family.

3. The medical and dental plans being offered during the June campaign are:

(a) Blue Cross/Aetna Major Medical (Blue Cross/Aetna);

(b) Blue Cross/WrapAround Plus (WrapAround Plus);

(c) Health Insurance Plan of Greater New York, Health Maintenance Organization (HIP/HMO);

(d) Kaiser Foundation Health Plan of the Northeast, Health Maintenance Organization (Kaiser/HMO);

(e) GHI Dental Plan (GHI).

Any change that may occur in regard to the plans being offered will be announced in an amendment to the present circular.

4. For enrolment purposes, applicants will be required to present proof of eligibility from their respective personnel or administrative officers attesting to their current contractual status. Eligible family members may also be enrolled at this time. Interested staff members should carefully review the current status of their family's enrolment, both as to the continued eligibility of children and/or inclusion of those newly eligible or not covered at present.

5. Staff members, particularly those who have no coverage under a United Nations plan or through another family member, are strongly urged to obtain medical insurance coverage for themselves and their eligible family members, especially since the high cost of medical care could result in financial hardship for individuals who become ill and/or are injured and have no such coverage.

6. Staff members are reminded that in the case of a staff member married to another staff member, the insurance coverage, whether at the two-person or family level, must be carried by the higher-salaried staff member.

7. The effective date of insurance coverage for all campaign applications, whether for enrolment, change of plan or change of family coverage, will be 1 July 1991.

Time and place of enrolment

8. The annual enrolment campaign at Headquarters will be held from 3 to 7 June 1991 at the offices of the Insurance Section of the Office of Programme Planning, Budget and Finance, room S-2765, between the hours of 10 a.m. and 5 p.m. STAFF MEMBERS AT HEADQUARTERS MUST COME IN PERSON TO THE INSURANCE SECTION OFFICE TO COMPLETE THE APPLICATION FORM AND OTHER FORMS AS NECESSARY. The staff of the Insurance Section will be available during the designated dates and hours to provide information and answer specific questions regarding the health plans being offered to staff. In addition, representatives of the insurance companies will be on hand from 3 to 5 June to provide information about the various insurance plans offered. The insurance company desks will be located in the staff activities area near the Secretariat cafeteria entrance.

9. Staff members are reminded that, except as provided in paragraphs 10 and 15 below, this will be the ONLY opportunity until June 1992 to enrol in the United Nations medical and dental insurance plans. This is also an opportunity to review current medical insurance coverages within or outside the Organization and either enrol in one of the United Nations plans or apply for changes within these plans, as may be necessary or desirable. Staff members who are satisfied with their coverage do not need to take any action at this time.

Enrolment between annual campaigns

10. Between annual campaigns, staff members and their family members may be allowed to enrol in the Headquarters medical and dental insurance plans ONLY if at least one of the following events occurs and application for enrolment is made within 31 days thereafter:

(a) In respect of medical insurance coverage, upon receipt of an initial appointment of at least three months' duration at Headquarters under the 100 or 200 series of the Staff Rules;

(b) In respect of dental insurance coverage, upon receipt of an initial appointment of at least six months' duration at Headquarters under the 100 or 200 series of the Staff Rules;

(c) Upon transfer to Headquarters, if insured in another United Nations or specialized agency plan at the time of transfer;

(d) Upon return from special leave without pay but only under the health scheme in which insured prior to taking leave (see para. 16 below);

(e) Upon marriage, birth or legal adoption of a child for coverage of the related family member.

Staff members who can demonstrate that they were on mission or annual or sick leave for the entire duration of the annual campaign may enrol within 31 days of their return to Headquarters.

11. In all cases, the completed application for enrolment or re-enrolment must be certified by the appropriate personnel or administrative officer and received by the Insurance Section within 31 days of the occurrence of the event giving rise to entitlement to enrol. Applications and inquiries with regard to changes relating to such events occurring between campaigns should be directed to the Insurance Section as follows:

Insurance Section
Office of Programme Planning, Budget and Finance
Room S-2765
United Nations Headquarters
New York, N.Y. 10017

12. Applications between enrolment campaigns based on any other circumstances or not received within the 31 days of the event giving rise to eligibility will not be receivable by the Insurance Section and will be returned. In this regard, it should be noted that termination of health insurance coverage under a scheme not offered by the United Nations will in no case give rise to any right on the part of a staff member or family member to immediate enrolment in a United Nations plan. If such termination occurs between annual enrolment campaigns, the staff member must wait until the next campaign to enrol in a United Nations plan. Staff members who for any reason may be uncertain about the continuity of their outside coverage are urged to consider enrolling in a United Nations scheme during the present campaign.

Cessation of coverage of family members

13. The Insurance Section should be notified immediately of changes in the staff member's family which result in a family member ceasing to be eligible, e.g., a spouse upon divorce or a child reaching the age of 25 years, marrying or taking up full-time employment. The responsibility for initiating the resulting change in coverage (e.g. from "staff member and spouse" to "staff member only" or from "family" to "staff member and spouse") rests with the staff member. Staff members who wish to discontinue coverage of a family member under a United Nations plan for any other reason may do so at any time, although this is strongly discouraged. Such deletions of family members from coverage should be communicated to the Insurance Section directly. It is in the interest of staff members to notify the Insurance Section promptly whenever changes in coverage occur in order to benefit from any reduction in premium contribution which may result. Any such change will be implemented on the first of the month following receipt of notification. No retroactive adjustments can be made as a result of failure to provide timely notification of any change to the Insurance Section.

After-service health insurance

14. Staff members are reminded that, among the eligibility requirements for after-service health insurance coverage, is that staff members must be enrolled in a United Nations scheme at the time of separation from service. A minimum of 5 years of prior coverage in a United Nations or specialized agency

health insurance scheme is necessary to qualify for unsubsidized after-service health insurance participation and 10 years of prior coverage for subsidized participation. In both cases, the staff member must be 55 years of age or over as of the date of separation. Full details on the eligibility requirements for after-service health insurance coverage are given in the relevant administrative instructions. 2/ It should also be noted that only family members enrolled with the staff member at the time of separation are eligible for continued coverage under the after-service health insurance programme.

15. After-service participants are also reminded that the restriction set out in paragraph 10 above, to the effect that staff members may switch from one insurance plan to another only during the period of the annual enrolment campaign, does not apply fully to them. As provided in administrative instruction ST/AI/172, an after-service participant may transfer from one United Nations health insurance scheme to another at any time, provided that the Insurance Section receives three months' written notice to enable the adjustment to be effected. This privilege is limited to transfers between medical plans (for example, from the Headquarters Blue Cross/Aetna plan to the Van Breda plan or other United Nations plan, should there be a change in residence within the United States or to another country).

Staff on special leave without pay

16. Staff members who are granted special leave without pay are reminded that they may retain coverage for medical and dental insurance during such periods or may elect to discontinue such coverage for the period of the special leave:

(a) Insurance coverage maintained during special leave without pay. If the staff member decides to retain coverage during the period of special leave without pay, the Insurance Section MUST be informed directly by the staff member of his or her intention at least one month in advance of the commencement of the special leave, in person if at Headquarters, or in writing if stationed away from Headquarters. At that time, the Insurance Section will require evidence of the approval of the special leave, together with payment covering the full amount of the cost of the coverage(s) retained (both the staff member's contribution as well as the Organization's share, since no subsidy is payable during such leave);

(b) Insurance dropped while on special leave without pay. Should a staff member decide not to retain insurance coverage(s) while on special leave without pay, no action is required upon commencement of the special leave;

(c) Re-enrolment upon return to duty following special leave without pay. Regardless of whether a staff member has decided to retain or drop insurance coverage(s) during a period of special leave without pay, it is essential that he or she re-enrol in the plan(s) with the Insurance Section upon return to duty, in person if at Headquarters, or in writing if away from Headquarters. This must be done within 31 DAYS OF RETURN TO DUTY. Failure to do so will mean that the staff member will be unable to resume participation

in the insurance plan(s) until the following annual enrolment campaign in the month of June.

Insurance plans and benefit changes

17. As of 1 July 1991, there will be four medical/hospitalization plans and one dental plan available to United Nations staff at Headquarters. They are described below. As may be seen from annex I, the premium rates for the Blue Cross/Aetna, HIP and Kaiser plans will increase by varying amounts, while the cost of the Blue Cross WrapAround Plus plan will decrease slightly. The cost of the GHI dental plan remains unchanged.

Conversion privilege

18. Participants who cease employment with the United Nations and are not eligible for after-service benefits may arrange for medical coverage under an individual contract. This provision applies to all plans currently offered. The conversion privilege, which is part of the United Nations group contracts with the respective insurance companies, means that the insurer cannot refuse to insure an applicant, and that no certification of medical eligibility is required. THE CONVERSION PRIVILEGE, HOWEVER, DOES NOT MEAN THAT THE SAME INSURANCE PREMIUM RATES OR SCHEDULE OF BENEFITS IN EFFECT FOR THE UNITED NATIONS GROUP POLICY WILL BE OFFERED IN RESPECT OF INDIVIDUAL INSURANCE CONTRACTS. It should be noted, moreover, that the conversion privilege may be exercised only for separating staff who will continue to reside in the United States as the insurers cannot write individual policies for persons residing abroad. In all cases, the conversion privilege must be exercised WITHIN 31 DAYS OF THE DATE OF SEPARATION. Details concerning conversion to individual policies under Aetna, Blue Cross and Blue Cross WrapAround Plus may be obtained from the Insurance Section, room S-2765. Details concerning conversion to individual policies under HIP, Kaiser and GHI dental should be obtained from those companies directly.

Where to address claims and benefit inquiries

19. Although the staff of the Insurance Section is available to assist staff members in administrative matters concerning participation in the various Headquarters insurance plans, claims questions should always be taken up directly with the insurance company concerned. The addresses and relevant telephone numbers of the insurance companies are listed in annex X to the present circular.

Blue Cross/Aetna Major Medical (Blue Cross/Aetna)

20. The Blue Cross/Aetna Major Medical (Blue Cross/Aetna) insurance plan is a full-indemnity plan that offers world-wide coverage for hospitalization (through Blue Cross) and surgical and medical expenses, and prescription drugs (through Aetna). Under the Blue Cross/Aetna plan, treatment for a covered illness or injury may be obtained from a physician or at a hospital of one's

own choosing. Hospital costs for semi-private accommodation are covered in full under Blue Cross. Under the Aetna component, the reasonable and customary levels of surgical, medical and prescription drug expenses are reimbursed at the rate of 80 per cent, after meeting an annual deductible of $125 per individual or $375 per family. When a participant has met the annual deductible and a further $1,000 in copayment (20 per cent of $5,000 of recognized expenses), Aetna will reimburse all further claims incurred in the year, subject to the "reasonable and customary" provision, at 100 per cent. The deductible and copayment requirement must be met each calendar year. There is no lifetime reimbursement limit under the Blue Cross/Aetna plan. Summaries of the benefits of the Blue Cross and Aetna components of the Blue Cross/Aetna plan are set out in annexes III and IV to the present circular respectively.

(a) Premium. Although the costs of the United Nations Blue Cross/Aetna plan reflect utilization of the plan by its participants, the increases in premium that are required for the rate renewal period commencing 1 July 1991 are quite modest when compared with premium increases for the non-United Nations community in the New York area having similar plan structures. The new premiums are shown in column (1) of annex I to the present circular. The percentages of salary contribution by staff members required to cover the increases are shown in column (1) of annex II to the present circular;

(b) Blue Cross - International participating hospitals. A list of hospitals outside the United States that accept the Blue Cross card for necessary IN-PATIENT hospital care is set out in annex IX. In most cases, the hospital will bill Blue Cross directly for covered expenses. For updates to this list, call 1-800-522-2855 (in the District of Columbia, 861-3800);

(c) Mandatory second surgical opinion. Staff are reminded that reimbursement in respect of 16 surgical procedures performed on a non-emergency basis requires a second surgical opinion and that failure to provide a second opinion, which must be furnished by a physician not associated or in practice with the physician who originally recommended and proposed to perform the surgery, WILL RESULT IN A REDUCTION OF THE REIMBURSEMENT FOR THE SURGERY BY 50 PER CENT. THE STAFF IS URGED ONCE AGAIN TO TAKE NOTE OF THIS REQUIREMENT. A complete listing of the surgical procedures subject to mandatory second opinion is provided in annex IV to the present circular;

(d) Aetna claims. The address to which Aetna claim forms should be sent is as follows:

Aetna Life Insurance Company
Unit 41
3541 Winchester Road
Allentown, Pa. 18195-0513

The customer service number for New York City area residents continues to be (212) 567-6969. The customer service number for non-New York City residents is (215) 391-1617. AS THE PLAN INCURS A SERVICE CHARGE FOR EACH CLAIM SUBMITTED, PARTICIPANTS ARE URGED NOT TO FILE CLAIMS WITH AETNA UNTIL ONE CLAIM OR A GROUP OF CLAIMS EQUALS OR EXCEEDS THE APPLICABLE ANNUAL DEDUCTIBLE;

(e) Access America. Blue Cross/Aetna subscribers are reminded of the existence of an additional benefit within the Blue Cross component called Access America. This facility provides an international travellers' 24-hour hotline assistance programme for obtaining medical care abroad, or within the United States, when at least 100 miles from one's normal place of residence. Participants who call the hotline numbers below will, where possible, be provided with referrals from a world-wide network of physicians, dentists, hospitals, pharmacies and other medical facilities. In addition, in most cases, Access America will settle the costs of EMERGENCY foreign hospital admission and treatment. If the emergency hospitalization occurs in the United States and the hospital does not accept the Blue Cross card, Access America will also settle the related costs directly with the hospital. In either case, it will then claim reimbursement directly from Blue Cross. In the case of hospitalization, Access America medical staff will contact the insured patient's local physician in order to monitor the case and services being received. In the event of an emergency hospitalization in the circumstances described above, it is important that Access America be contacted upon admission to the hospital or, at the latest, before discharge. It should also be emphasized that any hospital bill paid by the participant must be sent to Blue Cross for reimbursement, as Access America does not reimburse participants directly.

The hotline numbers are:

1-800-654-1901 - (in the United States, Canada, Puerto Rico and the Virgin Islands)

(202) 463-9662 - collect (from Alaska, Washington, D.C. and all other locations), or

Telex No. 706305 ACCESS WSH (from all locations)

When contacting Access America, be sure to identify yourself as a United Nations participant. Your Access America identification number is as follows:

2065-8-(UN INDEX NUMBER)-00.

Blue Cross/WrapAround Plus (WrapAround Plus)

21. The WrapAround Plus plan is a hybrid scheme blending some of the features of a health maintenance organization (HMO) (such as HIP) with some of the features of a full indemnity plan (such as Blue Cross/Aetna). The plan provides the participant with the possibility of selecting a physician from an

extensive listing of participating WrapAround Plus practitioners covering most medical specialities, in which case the only charge to the participant is $10. On the other hand, the participant may equally be treated by a physician who is not a participating practitioner in the plan. Medical services rendered by non-participating providers (whether physicians or otherwise) will be reimbursed subject to a deductible and 20 per cent copayment. The deductible and 20 per cent copayment requirement must be met each calendar year. The hospitalization component of the WrapAround Plus plan is exactly the same as that offered in conjunction with the Aetna plan, and is described in annex III to the present circular.

(a) Premium. As a result of favourable experience with the Blue Cross WrapAround plan last year, it has been possible to reduce the premium schedule slightly for the period 1 July 1991 to 30 June 1992. At the same time, the level of deductibles, which had been $200 per individual and $500 per family, will be reduced to $150 and $450 respectively;

(b) Participating providers. An extensive network of physicians covering the New York City, Westchester and Long Island areas participate in WrapAround Plus and accept as payment a fee schedule arranged with Blue Cross. These physicians are listed in a directory that is available to Headquarters staff for consultation at the offices of the United Nations Insurance Section (room S-2765); the Division of Personnel, United Nations Development Programme (UNDP) (room DC1-1876); and the Office of Personnel, United Nations Children's Fund (UNICEF) (room H-434); participants may also telephone Blue Cross at (212) 949-8090 to verify or obtain the name and address of a participating provider. No deductible has to be met, but instead, the participant pays a $10 copayment for each visit. If, however, a participating physician refers a patient to, or engages the services of, another provider who is non-participating, the deductible and 20 per cent copayment will apply in connection with reimbursement of the cost of the services rendered by the non-participating provider;

(c) Non-participating provider utilization. Should the participant choose to be attended to by a non-participating provider or be referred by a participating physician to a non-participating provider, WrapAround Plus will pay 80 per cent of the reasonable and customary charge after the participant has met a $150 deductible per individual/$450 per family. It should be noted that, with few exceptions, the following providers and medical services fall under the non-participating category and are subject to the deductible and copayment:

(i) Diagnostic laboratory and X-ray examinations;

(ii) X-ray, radium and radioactive isotope therapy;

(iii) Anaesthesia and oxygen;

(iv) Assistant surgeons assisting a primary surgeon;

(v) Physical therapy, physical medicine or rehabilitation;

(vi) Chiropractic services (limit of 20 visits).

After $900 of unreimbursed reasonable and customary medical expenses have been paid by the participant in a given year, further expenses will be reimbursed in full (100 per cent in lieu of 80 per cent);

(d) Prescription drugs. As announced in information circular ST/IC/1990/85 dated 31 December 1990, effective 1 January 1991, reimbursement for prescription drugs is at the rate of 80 per cent of the reasonable and customary cost of the drugs. There is no deductible in connection with the reimbursement of prescription drugs under this component of the WrapAround Plus plan;

(e) Access America. Blue Cross WrapAround Plus subscribers also benefit from the Access America facility, which is described in paragraph 18 (e) above.

An outline of the benefits of this plan is provided in annex V to the present circular. The premiums and percentages of salary contributions by staff applicable as of 1 July 1991 are shown in column (2) of annex I to the present circular and column (2) of annex II to the present circular, respectively.

Health Insurance Plan/Health Maintenance Organization (HIP/HMO)

22. This plan follows the concept of total prepaid group practice hospital and medical care, i.e., there is no out-of-pocket cost to the staff member for covered services at numerous participating medical groups in the Greater New York area, including New Jersey and certain areas in Florida. The costs of necessary emergency treatment obtained outside the covered area are included in the plan coverage. Additionally, prescription drugs and medical appliances are covered in full when obtained through HIP/HMO participating pharmacies and are prescribed by HIP/HMO physicians, or any physician in a covered emergency. Details of the HIP/HMO plan are outlined in annex VI. The premiums and percentages of salary contributions by staff applicable as of 1 July 1991 are shown in column (3) of annex I and column (3) of annex II to the present circular respectively.

Kaiser Foundation Health Plan of the Northeast (Kaiser/HMO)

23. The Kaiser Foundation Health Plan is an HMO, providing all medical-related services at any one of four health centre locations, accessible to staff members residing in northern Bronx, Westchester County and southern Connecticut as well as hospitalization when authorized by a Kaiser physician. Kaiser health centres accommodate not only physicians' offices but also laboratory, X-ray, pharmacy and mental health services. The costs of necessary emergency treatment obtained outside the covered area are included in the plan coverage. There is no ceiling on the use of authorized services,

no deductibles to cover and no insurance forms to complete. The plan coverage emphasizes early detection of medical problems before they become major illnesses.

24. The following two benefit modifications will come into effect on 1 July 1991:

(a) There will be an out-of-pocket cost of $3 (increased from $2) for each drug prescription filled at a Kaiser pharmacy;

(b) A $25 copayment will be assessed in respect of emergency care services. In this connection, participants should be advised that immediate notification (or within a reasonable period, if the participant is incapacitated) must be provided to Kaiser for in-patient emergency care services, while 48-hour notification is required for out-patient emergency care services i.e., within 48 hours after the care is received.

An outline of the benefits of this plan is provided in annex VII to the present circular. The premiums and percentages of staff contributions applicable as of 1 July 1991 are shown in column (4) of annex I and in column (4) of annex II to the present circular, respectively.

GHI Dental

25. There will be no premium increase for this plan for the year commencing 1 July 1991. A summarized schedule of benefits is contained in annex VIII to the present circular. A full schedule of benefits may be obtained either from the Insurance Section or GHI upon request. GHI has issued an updated Directory of Participating Dentists, containing the names, addresses and telephone numbers of a large selection of general dental practitioners, dental specialists, as well as several dental groups located throughout the New York area. Copies of the latest directory are available at the Insurance Section, room S-2765. The premiums applicable as of 1 July 1991 are shown in column (5) of annex I. The percentages of staff contributions applicable as of 1 July 1991 are set out in columns (5) and (6) of annex II to the present circular.

Notes

1/ The medical scheme applicable to staff at Headquarters appointed for less than three months or under the 300 series of the Staff Rules is described in information circular ST/IC/86/44 of 15 September 1986.

2/ ST/AI/172, ST/AI/172/Amend.2 and 3 and ST/AI/172/Add.2.

Annex I

HEADQUARTERS MEDICAL AND DENTAL INSURANCE
SCHEDULE OF MONTHLY PREMIUMS a/

(Effective 1 July 1991)

(United States dollars)

Type of coverage	Blue Cross/Aetna (1)	Blue Cross WrapAround Plus (2)	HIP/HMO (3)	Kaiser/HMO (4)	GHI Dental (5)
Staff member only	232.87	146.94	140.73	152.53	9.81
Staff member and one child b/	449.27	293.63	315.96	304.46	31.56
Staff member and spouse	485.80	358.88	315.96	304.46	23.37
Staff member and two or more eligible family members b/	560.39	358.88	410.04	411.02	49.00

a/ These premiums represent the total monthly premium for a given category of coverage. The cost of the medical/dental insurance plans at Headquarters is shared between the participants and the Organization. Staff members may determine their exact contribution by multiplying their "medical net" salary (see footnote a/ to annex II) by the related percentage of salary (shown in annex II).

b/ A child is eligible for coverage under these schemes until the end of the calendar year in which he or she attains the age of 25, provided that he or she is not married and not in full-time employment. Disabled children may be eligible for continued coverage after age 25.

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Annex II

CONTRIBUTION TO MEDICAL AND DENTAL INSURANCE PREMIUMS
AS A PERCENTAGE OF MONTHLY "MEDICAL NET" SALARY a/

(Effective 1 July 1991)

Type of coverage	Blue Cross/ Aetna (1) %	Blue Cross WrapAround Plus (2) %	HIP/HMO (3) %	Kaiser/HMO (4) %	GHI Dental with any medical plan b/ (5) %	GHI Dental alone (6) %
Staff member only	2.64	1.66	1.60	1.73	0.13	0.20
Staff member and one child	4.35	2.93	3.12	3.02	0.32	0.48
Staff member and spouse	4.41	3.16	3.12	3.02	0.24	0.36
Staff member and two or more eligible family members	4.95	3.16	3.67	3.56	0.47	0.71

a/ "Medical net" salary for insurance contribution purposes is calculated as gross salary, less staff assessment, plus language allowance, non-resident's allowance, post adjustment or the variable element of monthly subsistence allowance, as applicable. A staff member's monthly contribution is calculated by multiplying his or her monthly "medical net" salary by the percentage appropriate to his or her type of coverage. Actual contributions, however, are never more than 85 per cent of the corresponding premiums shown in annex I to the present circular.

b/ These rates for the GHI dental insurance plan are applicable only to staff members who are also enrolled in one of the Headquarters medical insurance plans and consequently pay one of the premiums in columns (1) to (4) of annex I.

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Annex III

OUTLINE OF BLUE CROSS HOSPITALIZATION INSURANCE COMPONENT APPLICABLE TO BOTH BLUE CROSS/AETNA AND BLUE CROSS WRAPAROUND PLUS

(See annexes IV and V for major medical components)

Hospital expenses in any legally constituted hospital for the following:

1. In-patient care

   Bed, board and general nursing care
   Other hospital services
   Mental or nervous disorders
   Pulmonary tuberculosis
   Physical therapy and rehabilitation
   Substance abuse rehabilitation
   Maternity care
   Hospice care
   Hemodialysis for kidney failure

2. Out-patient care

   Emergency first aid or minor surgery
   Pre-surgical testing
   Home health care
   Hemodialysis for kidney failure

3. Three hundred and sixty-five (365) days of care at full cost of bed and board based on semi-private room accommodation. Confinement in a hospital beyond 365 days will be borne by the major medical coverage combined with this hospitalization plan, i.e., Aetna or Blue Cross WrapAround Plus

4. Full cost of other hospital services while an in-patient, e.g., use of operating, cystoscopic and recovery room and equipment, X-ray examinations, laboratory and pathological examinations, prescribed drugs and medicine administered in hospital, etc.

5. Coverage for up to 210 days of in-patient hospice care in a certified hospice or hospital and home care and out-patient services provided by the hospice if the patient has been certified by his or her primary attending physician as having a life expectancy of six (6) months or less

6. Full cost of out-patient services for emergency treatment as follows:

   (i) Emergency first aid during the first visit for treatment of an accidental injury within 72 hours following such injury; or

(ii) Emergency care during the first visit for treatment within 12 hours of the onset of sudden or serious illness; or

(iii) Minor surgery.

Benefits will be provided for up to a total of 30 visits per calendar year

7. Full cost of out-patient services for pre-surgical testing conducted in the same hospital where surgery is scheduled

8. Full cost of home care, subject to specific conditions

9. Full cost of 30 days of hospitalization for substance (alcohol and/or drug) abuse detoxification and rehabilitation; limited to two 30-day benefit periods in a lifetime

10. Sixty out-patient visits per calendar year for each covered person for the diagnosis and treatment of alcoholism and substance abuse. Twenty of these visits are available for counselling for covered family members of the person with the alcohol or substance abuse problem. These 20 family counselling visits will be available whether or not the person is receiving treatment. All care under this benefit must be provided in a facility with an alcoholism treatment programme certified by the New York State Division of Alcoholism and Alcohol Abuse, or a substance abuse treatment programme certified by the New York State Division of Alcoholism and Alcohol Abuse, or a substance abuse treatment programme certified by the New York State Division of Substance Abuse Services as a medically supervised ambulatory substance abuse programme. Outside New York, the facility must be approved by the Joint Commission on Accreditation of Hospitals. Participants are advised to verify with the facility or with Blue Cross that the institution selected for treatment or counselling is properly certified and recognized by Blue Cross

11. Full cost of 45 days of in-hospital physiotherapy and rehabilitation

12. Full cost of 30 days of hospitalization for mental or nervous disorders, which may include detoxification treatment for alcohol or substance abuse

13. Full cost of in-patient and out-patient services for hemodialysis

14. Full cost for a mammogram, regardless of age, for women with a past history or family history of breast cancer, upon the recommendation of a physician. In addition, with or without the recommendation of a physician, coverage will be provided for:

(i) One baseline mammogram for women ages 35-39;

(ii) A mammogram every two years for women ages 40-49; and

(iii) An annual mammogram for women age 50 and older.

To be fully covered by Blue Cross under the above conditions, the mammogram must be performed in a hospital on either an in-patient or out-patient basis. UNDER THE AETNA COMPONENT OF THE PLAN, Aetna will reimburse the cost of a mammogram not otherwise covered by Blue Cross without any age or frequency limits. This benefit is subject to the normal deductible and copayment provisions of the Aetna plan.

Annex IV

AETNA MAJOR MEDICAL INSURANCE COMPONENT

A. Hospital expenses incurred after exceeding Blue Cross coverage maxima listed in annex V are covered by the Aetna Major Medical component. Covered expenses include charges for semi-private hospital room, board, general nursing care, X-ray and laboratory examination, etc.

B. Other covered medical expenses include:

1. The services of a legally qualified physician

2. The services of a private duty registered nurse (RN) other than a nurse who ordinarily resides in the staff member's home or who is a member of the staff member's family or his or her spouse's family. Private nursing services in a hospital are not generally considered necessary unless they are in lieu of intensive care or critical care unit nursing services. The circumstances under which private nursing charges are payable are very rare. If your physician recommends such treatment, please contact the Aetna claim office for guidance

3. Drugs and medicines obtainable only on a prescription of a legally qualified physician

4. Diagnostic laboratory and X-ray examinations

5. X-ray, radium and radioactive isotope therapy

6. Anaesthetics and oxygen

7. Rental of durable medical or surgical equipment

8. Artificial limbs and artificial eyes (eye examinations, eyeglasses and hearing aids are excluded)

9. Professional ambulance service when used to transport the individual from the place of injury resulting from an accident or where stricken by a disease to the first hospital where treatment is given. No other charges in connection with travel will be covered

10. A maximum of 50 out-patient visits per year to a medical doctor engaged in the practice of psychiatry (and, depending on the state in which the provider is licensed, for the services of a psychologist and psychiatric social worker). The maximum recognized charge per visit will be $60, reimbursable at 80 per cent, i.e., $48, with an annual maximum not to exceed $2,400 (50 visits x $48 = $2,400). Provider fees exceeding the $60-per-visit rate will be borne by the participant

C. Covered expenses listed under A and B above will be reimbursed at 80 per cent after the application of a calendar-year deductible of $125 per person or $375 per family, provided such expenses fall within the REASONABLE AND CUSTOMARY fee levels established by the insurer for the related medical service or procedure in the area of the doctor's place of business. In any calendar year, after an insured person's total unreimbursed expenses reach $1,000 (and after satisfying the deductible), covered expenses for that person will be reimbursed in full for the rest of that year

D. Special conditions apply to certain medical procedures for dental and cosmetic surgery, for out-patient psychotherapy and for convalescent facility expenses

E. Reimbursement will be made for second surgical opinion consultation expenses at 100 per cent after the deductible of $125 per person or $375 per family has been met (see sect. I below)

F. Coverage for 30 days of hospitalization for substance (alcohol and/or drug) abuse rehabilitation, after the 30-day Blue Cross benefit in annex V, item 9

G. Sixty out-patient visits per calendar year for the treatment of alcoholism or drug abuse diagnosed by a physician. Of these 60 annual visits, 20 may be utilized for the counselling of the patient's family if directly related to the patient's alcoholism or drug abuse

H. Unlimited overall lifetime reimbursement benefits

I. SURGICAL PROCEDURES REQUIRING A SECOND MEDICAL OPINION UNDER THE BLUE CROSS/AETNA INSURANCE SCHEME:

	Procedure	Explanation
1.	Bunionectomy	Removal of bunions
2.	Cholecystectomy	Removal of gall bladder
3.	Dilation and curettage	Dilation of cervix and scraping of uterus
4.	Excision of cataracts	Removal of cataracts
5.	Haemorrhoidectomy	Removal of haemorrhoids
6.	Hernia (inguinal) repair	Repair of hernia in the groin
7.	Hysterectomy	Removal of uterus
8.	Knee surgery	Knee operation

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	Procedure	Explanation
9.	Laminectomy	Removal of part of spine
10.	Mastectomy: partial or complete	Partial or complete removal of breast tissue
11.	Prostatectomy	Removal of prostate
12.	Septo-rhinoplasty	Nose surgery for functional improvement
13.	Spinal fusion	Surgical welding of spine segments
14.	Tonsillectomy and/or adenoidectomy	Removal of tonsils and/or adenoids
15.	Varicose veins	Removal and tying of varicose veins
16.	Coronary artery bypass	Heart surgery to bypass one or more blocked arteries feeding the heart

J. Coverage for the reasonable and customary charges for mammograms at 80 per cent without any age or frequency limits once the annual deductible has been met

Annex V

BLUE CROSS WRAPAROUND PLUS

A. Hospital expenses incurred after exceeding Blue Cross coverage maxima listed in annex IV above are covered by the Blue Cross WrapAround Plus component. Covered expenses include charges for semi-private hospital room, board, general nursing care, X-ray and laboratory examination, etc.

B. Major medical covered expenses under the Blue Cross WrapAround Plus scheme are as follows:

1. Surgical and medical care in or out of the hospital when using one of the participating WrapAround Plus plan doctors. (Please consult the Blue Cross WrapAround Plus directory or ask your physicians if they are enrolled in this plan as participating physicians. Alternatively, you may call (212) 949-8090 for up-to-date information on participating providers or verification that the physician of your choice does participate in the plan.) Please note that, if a participating physician refers a patient to, or engages the services of, another provider who is non-participating, the deductible and 20 per cent copayment will apply in connection with reimbursement of the cost of the services rendered by the non-participating provider (see also para. 4 below). The benefits under this arrangement include:

   (a) When using the services of a participating physician for an office or home visit, only a $10 copayment a/ per visit is required (no claims to file, no deductibles or additional out-of-pocket expenses to be met when being treated by a participating physician);

   (b) Well-baby care visits paid in full (six office visits up to age 1, one annual visit per year up to age 6); these visits are in addition to one in-depth examination performed in the hospital by a physician other than the attending physician who delivered the baby;

   (c) Surgical second opinion paid in full when rendered by a choice of physicians designated by Blue Cross (call (212) 481-2658).

2. When using a non-participating physician, reimbursement for the services provided will be subject to certain charges and limitations, as follows:

   (a) Deductible of $150 per individual/$450 per family;

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(b) Twenty per cent out-of-pocket copayment on the first $4,500 of reasonable and customary medical expenses ($900), after which the scheme pays 100 per cent in lieu of 80 per cent of covered expenses incurred in a given calendar year.

3. The following benefits are covered subject to the deductible and the out-of-pocket copayment set out in paragraph 2 above:

(a) The services of a private duty registered nurse (RN) other than a nurse who ordinarily resides in the staff member's home or who is a member of the staff member's family or his or her spouse's family, if deemed necessary by the attending physician;

(b) Rental of durable medical or surgical equipment;

(c) Artificial limbs and artificial eyes (eye examinations, eyeglasses and hearing aids are excluded);

(d) Professional ambulance service when used to transport the individual from the place of injury resulting from an accident or where stricken by a disease to the first hospital where treatment is given. No other charges in connection with travel will be covered.

4. Unless rendered by participating providers, the following services will be reimbursed at 80 per cent of the reasonable and customary fee and upon fulfilment of the deductible:

(a) Diagnostic laboratory and X-ray examinations;

(b) X-ray, radium and radioactive isotope therapy;

(c) Anaesthesia and oxygen;

(d) Assistant surgeons assisting a primary surgeon;

(e) Physical therapy, physical medicine or rehabilitation;

(f) Chiropractic services (limit of 20 visits).

C. Drugs and medicines obtainable only on the prescription of a legally qualified physician will be reimbursable at 80 per cent of the reasonable and customary cost of the drug with no deductible.

D. The payment of out-patient mental and nervous treatment is reimbursable at the rate of up to $45 per visit, with an annual maximum of $3,000. This benefit is also not subject to the above deductible nor to the 20 per cent copayment; however, participants are reminded that they are responsible for the difference between the amount payable by Blue Cross and the amount actually charged by the mental health practitioner.

E. The maximum lifetime benefit payable to the subscriber AND to each of his or her covered dependants UNDER THE MAJOR MEDICAL PORTION OF THIS PLAN will be $1,000,000.

Notes

a/ That portion of the medical expense borne by the subscriber.

Annex VI

HIP/HEALTH MAINTENANCE ORGANIZATION PLAN

Type of benefit	HIP/HMO coverage
Hospital services	Covered in full when authorized by HIP/HMO physician
In-hospital physician's services	Covered in full if rendered by HIP/HMO physician
Private duty nursing	Covered in full when authorized by HIP/HMO physician or by any physician in a covered emergency
Skilled nursing facility	No limit on number of days when care is in lieu of hospitalization. Care must be arranged by HIP/HMO physician
Visits to physician's office/ health centre	Covered in full at any HIP/HMO medical centre or if care is rendered by HIP/HMO physician
House calls	Covered in full when authorized by HIP/HMO physician or emergency service programme
Maternity care	No waiting periods. Covered in full when care is rendered by HIP/HMO physician. Prenatal, postnatal and well-baby check-ups are covered in full
Preventive care:	
Annual physicals, well-baby care, eye examinations, hearing tests, diagnostic X-rays, laboratory tests, immunizations and allergens	Covered in full when care is rendered by a HIP/HMO physician. Eye examinations are covered in full when rendered by a HIP/HMO physician (eyeglasses and hearing aids are excluded)
Mental health services:	
In-patient	Covered in full for 30 days per calendar year for mental or nervous disorders
Out-patient	HIP/HMO has its own mental health centres that provide psychotherapy and counselling for adults and children with mental or emotional problems. Individual, family or group therapy sessions are provided as long as treatment is effective. Intensive psychotherapy is excluded

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Type of benefit	HIP/HMO coverage
Alcoholism and substance abuse	
In-patient	Covered in full for up to 30 days in any calendar year in a state-certified alcoholism or substance abuse treatment facility
Out-patient	Medical services for diagnosis and treatment of alcoholism or substance abuse for a period not to exceed 60 visits in any calendar year. HIP/HMO mental health centres will be used for the out-patient services
Emergency services:	
In area	HIP/HMO has an emergency service programme that is in operation when your medical group is closed. This provides the HIP/HMO subscriber with a 24-hour, 7-day service
Out of area	Hospital service: In-patient - covered in full; Out-patient - covered in full, when care is received within 12 hours of onset of illness or within 72 hours (three days) following injury; Doctor services - HIP/HMO pays customary and reasonable non-HIP/HMO physician fees for covered emergency illness or accidental injury
Prescription drugs and medical appliances	Covered in full when obtained through HIP/HMO participating pharmacies. The drugs and appliances must be prescribed by HIP/HMO physicians, or any physician in a covered emergency

Annex VII

KAISER FOUNDATION HEALTH PLAN OF THE NORTHEAST (KAISER/HMO)

Type of benefit	Kaiser/HMO coverage
Hospital services	Covered in full when authorized by a Kaiser physician
In-hospital rehabilitation	60 days of in-patient rehabilitation care per condition provided in a hospital or skilled nursing facility
In-hospital physician's services	Covered in full if rendered or authorized by a Kaiser physician
Private duty nursing	Covered in full when considered medically necessary
Skilled nursing facility	Covered in full for 100 days per contract year when prescribed, arranged and approved by a Kaiser physician
Visits to physicians' office/health centre	Covered in full at any Kaiser medical centre nation-wide or if rendered by or referred by a Kaiser physician
House calls	Covered in full for a registered nurse or Kaiser physician when medically necessary. Limited to the service area
Maternity care	No waiting period. Covered in full when rendered by a Kaiser physician. Prenatal, postnatal and well-baby check-ups are covered in full
Preventive care:	
Annual physicals, well-baby care, eye examinations, hearing tests, diagnostic X-rays, laboratory tests, immunizations and allergens	Covered in full when rendered or authorized by a Kaiser physician
Mental health services:	
In-patient	Covered in full for 30 days per contract year

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Type of benefit	Kaiser/HMO coverage
Out-patient	Covered in full at Kaiser Medical Center for short-term evaluation or crisis intervention for visits 1-10 per contract year. Visits 11-20 are covered subject to a 25 per cent copayment of the Kaiser fee-for-service rate. Visits 21-30 are covered at 50 per cent of the Kaiser fee-for-service rate
Alcoholism treatment:	
In-patient	Covered in full for detoxification only
Out-patient	Covered in full up to 60 out-patient visits per calendar year for the diagnosis and treatment of alcoholism
Emergency services:	
$25 copayment	A $25 copayment will be assessed for emergency care services. Immediate notification to Kaiser required if admitted to a hospital (or within a reasonable period of time if incapacitated). Out-patient emergency care requires 48-hour notification to Kaiser, i.e., within 48 hours after the care is received
In area	Covered in full for life-threatening conditions for care received in a hospital emergency room. Kaiser must be notified first, if possible, or, if not possible, within 48 hours of treatment
Out of area	Covered in full for reasonable charges for sudden onset of an illness or accident requiring immediate attention. Kaiser must be notified within 48 hours
Prescription drugs and medical appliances	$3 copayment for all prescriptions prescribed by Kaiser physicians and obtained at Kaiser pharmacies. Durable medical equipment is covered in full. Coverage is provided for internal prosthetic devices and for their replacement

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Annex VIII

GHI DENTAL INSURANCE PLAN (SPECTRUM) a/

	Maximum allowance $
CROWNS AND INLAYS	
Porcelain jacket	125
3/4 cast gold crown	125
Full cast gold crown	150
with acrylic veneer	175
with porcelain veneer	200
Acrylic or vinyl jacket crown	100
Inlays used as abutments	
Two surfaces	75
Three surfaces	100
Pontics	
Tru-pontic	100
Pontic of other type	100
FILLINGS AND RESTORATIONS	
Silver amalgam	
One surface	10
Two surfaces, same tooth	20
Three or more surfaces, same tooth	25
Composite fillings	
Per filling	15
Maximum per tooth	25
REPAIR OF PROSTHETIC APPLIANCES (Maximum $75 per calendar year)	
Repairing body of broken denture	25
Replacing broken teeth in denture not requiring other repairs:	
First tooth	25
each additional tooth	8
Replacing broken teeth in broken denture, per tooth	8
Reattaching clasp on denture, clasp intact	25
Replacing broken clasp on denture with new clasp	40

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	Maximum allowance $
EXTRACTIONS	
Impacted teeth	
Completely covered by bone	100
Partial bony impaction	75
Soft tissue impaction	50
Difficult extractions requiring bone removal, flap and sutures	35
Routine extraction	15
ORAL SURGERY	
Removal of cyst	50
Alveolectomy, maximum per jaw	50
Excision of tissue for biopsy	
Surgery	20
Report	15
ROOT CANAL THERAPY	
One canal, per tooth	100
Two canals, per tooth	125
Three or more canals per tooth	175
PERIODONTICS	
Per treatment	20
Maximum, five treatments, per calendar year	100
Periodontal surgery per quadrant (five or more teeth)	65
PROSTHETIC APPLIANCES	
(No replacement or interchange within a five-year period will be made for any appliance originally paid for by GHI.)	
Dentures, full or partial	
Full, permanent, each jaw	275
Partial, bilateral acrylic or comparable base, two or more full clasps and rests, each jaw	150
Partial, bilateral, chrome cobalt alloy, two or more full cast clasps with occlusal rests, acrylic attachments and porcelain or acrylic teeth for each jaw	300
Relining or rebasing, maximum 1 each denture, every 3 years	75

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	Maximum allowance $
ORTHODONTICS	
(Benefits are available only to eligible children to the end of the calendar year in which they become age 25.)	
Diagnosis and initial orthodontic appliances	200
Active treatment per month of treatment	50
Maximum, 24 months	1 000
Passive treatment, per 6 months of treatment	25
Maximum, 18 months	75
OTHER SERVICES	
Examination and charting, one per calendar year	10
Prophylaxis (cleaning) two per calendar year	
(person under 12)	7
(person 12 or over)	10
14 standard X-rays (full mouth series), one every three years	15
4 bitewing X-rays each calendar year	10

PRE-DETERMINATION AMOUNT

If a course of treatment can reasonably be expected to involve covered dental expenses of $200 or more, a description of the procedures to be performed and an estimate of the dentist's charges should be filed with GHI before the course of treatment begins.

Notes

a/ This outline does not cover all services but represents a list of the most commonly used dental services.

Annex IX

BLUE CROSS - INTERNATIONAL PARTICIPATING HOSPITALS

The following list of hospitals accept the Blue Cross card for necessary IN-PATIENT hospital care. In most cases, the hospital will bill Blue Cross directly for covered expenses. For updates to this list, call 1-800-522-2855.

AUSTRALIA	**ADELAIDE** Wakefield Memorial Hospital	**ASHFORD** Ashford Community Hospital	**AUCHENFLOWER** Wesley Hospital
	BAULKHAM HILLS Baulkham Hills Private Hospital	**BICTON** Bicton Private Hospital	**BRISBANE** Holy Spirit Hospital St. Andrew's War Memorial Hospital
	BURNIE Burnie North Western General Hospital	**CAIRNS** Calvary Private Hospital	**DARLINGHURST** St. Vincent's Private Hospital
	EAST MELBOURNE Freemasons Private Hospital St. Andrew's Private Hospital	**FITZROY** St. Vincent's Hospital (Public) St. Vincent's Private Hospital	**FRANKSTON** Peninsula Private Hospital
	GOSFORD North Gosford Private Hospital	**GRANGE** Western Community Hospital	**HOBART** Royal Hobart Hospital St. John's Hospital
	LAUNCESTON Launceston General Hospital	**MACKAY** Mater Miscricordiac Hospital	**MEREWETHER** Lingard Private Hospital
	MOUNT LAWLEY St. Anne's Hospital	**NORTH ADELAIDE** Calvary Hospital Memorial Hospital St Andrew's Hospital	**NORTH SYDNEY** Mater Miscricordiac Private Hospital
	PERTH Mount Hospital	**PRAHRAN** The Alfred Hospital (Public)	**RICHMOND** The Epworth Private Hospital
	SOUTH BRISBANE Master Miscricordiac Hospital	**SUBIACO** St. John of God Hospital	**TOORAK GARDENS** Burnside War Memorial Hospital
	TOWNSVILLE Mater Miscricordiac Hospital	**WAGGA WAGGA** Calvary Private Hospital	**WAHROONGA** Sydney Adventist Hospital
	WINDSOR The Avenue		
BAHAMAS	**NASSAU** Doctors Hospital		
BELGIUM	**BRUSSELS** Cliniques Universitaires Saint Luc Hopital Erasme		

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BERMUDA	**PAGET (HAMILTON)** King Edward VII Memorial Hospital		
BRAZIL	**BRASILIA** Casa de Saude o Clinica Santa Lucia S.A.	**RIO DE JANEIRO** Clinica Sao Vincente Hospital Samaritano	
CAMEROON	**DOUALA** Polyclinic Bonanjo		
CANADA	Hospitals throughout Canada will accept the Blue Cross and Blue Shield card and bill a subscriber's home Blue Cross and Blue Shield Plan directly		
CHILE	**SANTIAGO** Clinica Las Condes		
COLOMBIA	**BOGOTA** Clinica de Marly, S.A.		
ECUADOR	**QUITO** Hospital Metropolitano		
ENGLAND	**BERKSHIRE** The Princess Margaret Hospital	**BIRMINGHAM** AMI Priory Hospital	**BUCKINGHAMSHIRE** AMI Chiltern Hospital
	CHESHIRE AMI Alexandra Hospital	**KENT** AMI Chaucer Hospital AMI Sloane Hospital	**LONDON** AMI Blackheath Hospital AMI Portland Hospital for Women and Children The Harley Street Clinic Humana Hospital Wellington The Princess Grace Hospital
	MIDDLESEX The Clementine Churchill Hospital	**NOTTINGHAM** AMI Park Hospital	
FRANCE	**NICE** Clinque Medicale Plein Ciel Institute Arnault Tzanck	**PARIS** The American Hospital of Paris	
GABON	**LIBREVILLE** La Clinique des Trois Quartiers		
GREECE	**ATHENS** Hygeia Hospital		
HONG KONG	Hong Kong Adventist Hospital		

IRELAND	**CORK** Bon Secours Hospital	**DUBLIN** Mater Private Hospital	**LIMERICK** St. John's Hospital
ISRAEL	**AFULA** Central Emek Hospital	**BEER-SHEVA** Soroka Medical Center	**EILAT** Yoseftal Medical Center
	HAIFA Carmel Medical Center	**HERZLIYA** Herzliya Medical Center	**KFAR-SABA** Meir General Hospital
	PETAH-TIQVA Beilinson Medical Center Hasharon Hospital	**REHOVOT** Kaplan Hospital	
ITALY	**ROME** Salvator Mundi International Hospital		
JAPAN	**KOBE** Kobe Kaisei Hospital		
KENYA	**NAIROBI** The Nairobi Hospital		
MARTINIQUE	**PORT-DE-FRANCE** Meynard Hospital		
MEXICO	**GUADALAJARA** Hospital del Carmen Hospital Mexico Americano	**MEXICO CITY** The American British Cowdray Hospital Hospital Los Angeles	**MONTERREY** Hospital San Jose de Monterrey
MONACO	**MONACO** Centre Cardio Thoracique de Monaco		
PANAMA	**PANAMA CITY** Centro Medico Paitilla		
PERU	**LIMA** Clinica Ricardo Palma		
PORTUGAL	**LISBON** Hospital da Cruz Vermelha Portuguesa		
SAUDI ARABIA	**ALKHOBAR** Almana General Hospital	**RIYADH** Al Hammadi Hospital	

SCOTLAND	GLASGOW AMI Ross Hall Hospital		
SENEGAL	DAKAR Clinique Casabous Clinique Hubert		
SINGAPORE	The American Hospital of Singapore Mount Elizabeth Hospital		
SPAIN	ALICANTE Sanatorio del Perpetuo Socorro	BARCELONA Clinica Quiron Institut Dexeus	MADRID Ruber Hospital Ruber Internacional Hospital
	PAMPLONA Clinica Universitaria De Navarra	VALENCIA Clinica Casa de Salud	
SWITZERLAND	BERN Klinik Beau-Site	GENEVA Hospital de la Tour et Pavillon Gourgas	LAUSANNE Clinique Cecil
	SION Clinique Generale de Sion	ZURICH AMI Klinik Im Park	
TAIWAN	TAIPEI Central Clinic and Hospital Country Hospital Taiwan Adventist Hospital		
THAILAND	BANGKOK The Bangkok Nursing Home Hospital		
TRINIDAD	PORT-OF-SPAIN Port-of-Spain Adventist Hospital		
U.S. VIRGIN ISLANDS	ST. CROIX St. Croix Hospital and Community Health Center	ST. JOHN Myra Keating Smith Community Health Center	ST. THOMAS St. Thomas Hospital and Community Health Center
VENEZUELA	CARACAS Centro Medico de Caracas Hospital de Clinica Caracas		
WEST INDIES	ANTIGUA Adelin Medical Center	ST. LUCIA St. Jude Hospital	ST. VINCENT The Botanic Hospital

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Annex X

INSURANCE CARRIER ADDRESSES AND TELEPHONE NUMBERS
FOR CLAIMS AND BENEFIT INQUIRIES

I. BLUE CROSS HOSPITALIZATION AND BLUE CROSS WRAPAROUND/PLUS

Empire Blue Cross
622 Third Avenue
23rd Floor/Attention: George Haranis
New York, New York 10017

Tel: (212) 490-4141 (For general questions)

(212) 476-3417/3419 (For more specific questions concerning the United Nations Group Plans)

(212) 949-8090 (To verify or obtain a participating provider under the WrapAround Plus major medical plan)

II. AETNA MAJOR MEDICAL PLAN

Aetna Life Insurance Company
Unit 41
3541 Winchester Road
Allentown, Pa. 18195-0513

Tel: (212) 567-6969 (for New York residents)
(215) 391-1617 (for non-New York residents)

III. HIP/HMO

HIP Member Services Department
220 West 58th Street
New York, New York 10019

Tel: 1-800-HIP-TALK (1-800-447-8255)

IV. KAISER/HMO

Kaiser Foundation Health Plan
7-11 South Broadway
White Plains, New York 10601

Tel: (914) 682-0025

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V. GHI DENTAL PLAN

Group Health Incorporated (GHI)
P.O. Box A965, Times Square Station
New York, New York 10108

Tel: (212) 760-6466/6709